Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: KILLEEN INJURY CLINIC 5931 DESCO DRIVE DALLAS, TX 75225	MFDR Tracking #:	M4-09-9592-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: MIDWEST EMPLOYERS CASUALTY CO. REP. BOX #: 19	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Enclosed are copies of the EOB's, claims, DWC-060 and documentation. These claims were denied payment because of extent of injury. Ms. Fleming's extent of injury was resolve per the CCH held on 05/27/08. This patient was referred to our office by her treating physician. Preauthorization was obtained for her treatments. These claims were again denied after reconsideration was completed..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $19,843.70
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The treatments and charges that are the subject of this dispute are for body part/conditions that DWC has determined are not part of the compensable injury. Provider utilized diagnosis code 840.8 which concerns Sprain and Strains of Joints and Adjacent Muscles – Other Specified Site of Should and Upper Arm… The hearing officer decided as follows: the injury does not extend to the cervical spine, bilateral shoulders, or depression; that the claimant did not have disability from 12/15/06 though 1/28/07 or form 9/26/07 through the date of the hearing; that the first certification of MMI and IR became final, and that the carrier did not waive the right to contest the compensability of the injury to the cervical spine or bilateral shoulders. The Appeals Panel upheld that decision and it is now final. Carrier is not responsible for charges for treatment to non-compensable body parts/conditions..."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
09/22/08	CPT Code 97750 (52.83 ÷ 38.087) x $26.69 = $37.02 x 6 units = $222.13. The Requestor is seeking $218.70	1 – 4, 6	$ 218.70
10/14/08, 10/16/08 10/20/08, 10/22/08, 10/23/08, 10/24/08, 10/27/08, 10/28/08, 10/29/08, 10/31/08, 12/09/08, 12/10/08, 12/17/08, 12/18/08, 12/19/08, 12/22/08, 12/23/08, 12/24/08, 12/29/08, 12/30/08	CPT Code 97799-CP-CA (19 days @ 8 hrs/day = 152 hours x $125.00/hour = $19,000.00 and 1 day @ 5 hours x 125/hour = $625.00. 19,000.00 + $625.00 = $19,625.00	1 – 3, 5	$19,625.00
Total:			$19,843.70

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.203, titled *Medical Fee Guideline for Professional Services* and 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, both effective March 1, 2008 set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "219 – Based on Extent of Injury."
2. According to the Contested Case Hearing of March 27, 2008, which was upheld by the Appeals Panel, the compensable injured does not extend to the cervical spine, bilateral shoulders, or depression. The claimant sustained a compensable bilateral biceps strain injury on May 10, 2006.
3. The Requestor billed the insurance carrier for a Physical Performance Evaluation and a Chronic Pain Management program using ICD-9 code 840.8. ICD-9 code 840 is defined as sprains and strains of shoulder and **upper arm** (emphasis added) and ICD-9 code 840.8 is: Other specified sites of the shoulder and upper arm. In review of the ICD-9 code book there is no specific ICD-9 code for the compensable bilateral biceps strain. Since the biceps are considered part of the upper arm, the code used by the Requestor is the proper diagnosis code. Therefore, the disputed dates of service will be reviewed in accordance with the applicable Statue and Rules in effect at the time the services were rendered.
4. CPT Code 97750 for date of service 09/22/08 denied as "219." The Requestor has submitted the Physical Performance Evaluation report supporting the service was rendered as billed. Therefore, per Division rule at 28 TAC Section 134.203(b)(1) and (c)(1) and 133.307(c)(2)(C) reimbursement in the amount of $218.70 is recommended.
5. CPT Code 97799-CP-CA for dates of service 10/14/08 through 12/30/08 denied as "219." The Requestor has submitted the Chronic Pain Management notes to support treatment was rendered as billed. Therefore, per Division rule at 28 TAC Section 134.204(h)(5)(a-b) reimbursement in the amount of $19, 625.00 is recommended.
6. Per review of Box 32 on CMS-1500, zip code 76541 is located in Bell County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.203, 134.204, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $19,843.70 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Auditor Medical Fee Dispute Resolution	Date
Authorized Signature	Manager, Medical Fee Dispute Resolution	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.